Clinical Notes :

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

THE ASSOCIATION OF SLOW PULSE AND SYNCOPAL ATTACKS.

BY W. ELLIOT RISDON, M.D., B.S. LOND.

In this connexion the following brief notes of a case which presented some difficulty during life may possibly be of interest.

The patient, a professional man, aged thirty-eight years, of athletic habits and previous good record, was suddenly seized with faintness whilst quietly walking along the street. When first seen he appeared to be dying, but after an hour's treatment he rallied. His heart was then carefully examined. The cardiac impulse was in the normal situation and the sounds were free from murmur; the action was regular, with a pulse of 70 per minute. On inquiry he stated that this was his normal pulse-rate and that he had never previously had any indication of cardiac weakness. After resting for some hours in the recumbent posture his circulation appeared so satisfactorily re-established that it was thought possible to move him with safety. On sitting up, however, his heart again failed and his condition became critical. After remaining pulseless and deeply unconscious for two hours an improvement again took place and the pulse gradually became of good force, beating from 24 to 30 per minute. There were marked pallor and slight coldness of the extremities, but no pain. The respirations were 14 and the urine was normal. After remaining in this condition for some time the pulse was noticed to become intermittent. This was at first only occasional, but soon became more frequent until there were from ten to twelve dropped beats in succession, the heart resuming with normal force after an interval of twenty or thirty seconds. During this interval there was brief loss of consciousness with slight tonic spasm of the muscles of the face and limbs and dilated pupils, and no sound of ventricular contraction could be detected. The case terminated fatally three days later, but there was no material change in the character of the symptoms, the pulse remaining abnormally slow to the end.

Necropsy.—On post-mortem examination the left ventricle was found to be somewhat hypertrophied and streaked with fat at one spot near the apex; the valves were healthy. There was a small patch of atheroma in the first part of the aorta, but the coronary arteries were normal. The lungs were oedematous, but all the other organs were healthy.

The symptoms in this case appear a little difficult of explanation except upon the theory of disturbed cardiac innervation, for which, however, there was no apparent cause. The temporary lapses into unconsciousness and the attacks of tonic spasm appeared to be the result of cerebral anæmia.

Chancery-lane, W.C.

DYSTOCIA FROM RELATIVE SHORTNESS OF THE FUNIS.

BY JOHN A. LYCETT, M.D. ST. AND.,

SURGEON TO THE WOLVERHAMPTON HOSPITAL FOR WOMEN.

A WOMAN, aged thirty-three years, the mother of two fine healthy girls, the younger three years old, was recently attended by me at full term. The labour was slower in progress compared with her previous confinements, the pains being of short duration and not strong. The presentation was first cranial or left occiput anterior. When the head was bearing upon the perineum evidence of the nature of the difficulty became manifest by great retraction between the pains, which were becoming shorter and less effectual, though not from exhaustion, as she continued cheerful with a good pulse. Pelvic examination showed no cause, there being ample space with yielding soft parts, and the nature of the presentation was further confirmed by feeling with ease

the pinna of the left ear. Abdominal examination showed a single gestation with the placenta at the fundus, where the rotundity became much less defined during uterine action. Though during labour a firm bandage had been applied round the abdomen it became evident that nature, unaided, could not effect delivery, which had appeared so imminent for over an hour. Forceps were therefore used and the occiput carried round the symphysis without injury to the perineum; this was accompanied by hæmorrhage. The diagnosis was now verified by finding a strong, rather thick cord passing over the thorax round the back of the neck. The tension was so great that it was impossible to slip it either over the head or shoulders, so I divided it between forceps, as it was uncertain which was the foetal end. The shoulders and arms were now freed, and a male child weighing over eleven pounds, and twenty inches in length, was delivered. As hæmorrhage continued rather free and the placenta could not be expelled by Crédé's method ergot was given, and the hand immediately introduced, when about a fifth part of the placenta was found attached at the fundus with a large clot. I regret that the length and strength of the cord were not ascertained, but it was about nineteen inches long, and as an average cord shown by the late Dr. Matthews Duncan¹ will bear a weight of eight pounds this evidently would not have broken under a weight of twelve pounds. Generally when the cord is too short the placenta under the tensile force of labour becomes detached from the uterus as in this case, but the cord has been known to tear from either the placental or umbilical site, and when weaker than normal snap through during labour, as related by Dr. Johnson.² It is not uncommon for the cord to encircle some part of the child, and less marked degrees of relative shortening may arise sufficient to retard delivery, even to partially detaching the placenta without being recognised. During an experience of nearly twenty-five years I have no note of labour being impeded from actual shortness, but have met with several where relative shortness has been a cause of dystocia. This, however, is the only occasion where the symptoms and physical conditions were sufficiently obvious to enable a diagnosis to be, with reason, inferred before delivery. The mother predicted a male child partly from the different character of the labour, and also from carrying it during the later months much higher than in the previous gestations.

Wolverhampton.

CASE OF TRANSPOSITION OF THE VISCERA, WITH A TRICELIAN HEART.

BY HENRY JELLETT, M.D., B.CH., B.A.O. DUB.,

ASSISTANT MASTER, ROTUNDA HOSPITAL, DUBLIN.

IN June, 1896, I was summoned to see a baby who had been just born in the Rotunda Hospital in an asphyxiated condition. When seen, the child was respiring feebly, the heart was weak and irregular, and the face and body were cyanosed. I commenced Schultze's method of artificial respiration, gave the child hot baths, and rubbed the lips and mouth with whisky. I felt for the heart in the usual manner—i.e., by pressing the fingers upwards under the ribs a little to the left of the middle line—but I was unable to feel its pulsations owing to the presence of what I at first took to be a greatly enlarged liver. I then palpated the abdomen on the right side to determine the size of the liver. Instead of finding it there as I expected, I was able to press my fingers upwards beneath the ribs, and to feel the pulsations of the heart to the right of the middle line. It was plain, then, that it was a case of transposition of at least the heart and liver. All attempts to revive the infant failed, and the child died in ten minutes. I made a post-mortem examination of the body the same day, and discovered that it was a case of complete transposition of the viscera. The normal position of the lungs, heart, liver, stomach, spleen, and intestines was reversed. The heart was almost twice the normal size, and when opened was found to have but three cavities—two auricles which opened into a common ventricle.

Many cases of partial transposition of the viscera have been recorded, but the number of cases in which complete transposition occurred is comparatively few. Two theories as to

¹ Transactions of the Obstetrical Society, vol. xxiii., 1881; Brit. Med. Jour., vol. ii., 1881, p. 857.

² Brit. Med. Jour., vol. ii., 1882, p. 132.

its causation are suggested. Von Baer has found that in a few instances the embryo lies with its left side directed towards the yolk, whereas the right side is normally in this position. He considers this condition in all probability the cause of the transposition. Dr. Fraser, in a communication read before the Royal Academy of Medicine in Ireland (May 25th, 1894), thinks the transposition may be due to the subject having been one of twins which were developed from a single ovum and in which dichotomy was complete. He also exhibited a thoracopagus monster, in which the right-hand foetus had complete transposition of the viscera.

Dublin.

A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

ST. GEORGE'S HOSPITAL.

A CASE OF TUMOUR GROWING FROM THE BASILAR PROCESS OF THE OCCIPITAL BONE AND COMPRESSING THE MEDULLA AND PONS; NECROPSY; REMARKS.

(Under the care of Dr. H. D. ROLLESTON.)

THIS is a very interesting account of an unusual form of tumour of the base of the brain, which, growing from the bone, produced symptoms, which are carefully described, by pressure on the important parts at the base. "Tumours of the base of the brain¹ deserve special mention. They usually spring from the dura mater, sometimes from the bone. Sarcoma and carcinoma are most frequent; less common are psammoma, cholesteatoma, syphilitic gumma, enchondroma, fibroid growth, and hydatid cyst. The petrous portion of the temporal bone, or the dura mater over it, is the part from which growths most frequently spring. The neighbourhood of the sella Turcica is another common seat, and sometimes they originate in the posterior fossa, adjacent to the foramen magnum. They may spring from the bone in this part. They often attain a considerable size, even that of a hen's egg, and compress the superjacent brain." For the notes of this case we are indebted to Dr. W. Thomas, house physician.

A boy, aged seventeen years, was admitted into St. George's Hospital on Aug. 27th, 1896, complaining of seeing double when he looked to the left. He said that two months ago during very hot weather his speech became indistinct. He also suffered from severe pain in the top of his head. He was sick every morning, retching a good deal, but bringing up very little. This continued for three weeks. The sickness then ceased and his speech became clearer. The headache remained and he noticed that on looking to the left he saw double. He was a heavy-looking boy and took some little time to collect his thoughts on being asked questions. The right side of his face seemed to move less easily than the left, but as it never altered it may possibly have only been habitual and not connected with his disease. On asking him to put out his tongue it was noticed that it was pushed over to the left side. It was covered with a thick, creamy, yellow fur, and the left side felt flabby when pinched between the fingers. The movements of the eyes were perfect in all directions except the outward movement of the left eye. The left eye did not move outwards so quickly or so far as the right eye did inwards. There was some loss of power in the left external rectus. It was in performing this movement that diplopia resulted. The pupils were equal and reacted to light and accommodation. The fundi were normal. No evidence of paralysis of the sterno-mastoid or trapezius could be made out. The knee-jerks were normal, the left being slightly weaker than the right. Superficial reflexes were present, but sluggish. There was no ankle clonus. There was no loss of power in the arms and legs. The right grip was stronger than the left. He was able to walk perfectly and could turn round quickly without

faltering. The heart and lungs were normal. The abdomen was slightly retracted, but otherwise normal. There was on marked wasting. The pulse was 110, regular, and fairly strong. The urine was clear, specific gravity 1020, no albumin or sugar. There was a deposit of phosphates on boiling. His bowels were most irregular, acting only with enemata. Eventually they were found to act better with German brandy and occasional enemata. The tongue did not clean after this, so its coat was thought to be due to imperfect mastication. On getting up in the morning he complained of giddiness and a feeling of nausea. After two or three days he became sick every morning and sometimes during the day. The headache continued, the pain being most intense in the occipital region. He was given quinine and iodide of potassium, but without any effect except slight coryza and an acne rash. On Sept. 25th he was given fifteen grains of sulphonal with ten grains of phenacetin twice a day. This relieved him completely of his headache, but kept him in a drowsy condition during the day in addition to making him sleep at night. It was found that giving him occasional doses at night kept him free from pain. This treatment was continued for seven weeks without producing any toxic effects. About a week after his admission it was noticed, after swallowing some milk, that he coughed and a portion of it regurgitated through his nose. At the same time his voice acquired a slight nasal intonation and his speech became somewhat thick. On examining the fauces the soft palate was seen to act sluggishly, the left side more so than the right. There was some response to a stroke with a pen-holder on the right side, but hardly any at all on the left. He, however, continued to take his food well for some time after this without any further regurgitation taking place. The giddiness and retching became more marked on rising. His gait became unsteady and he complained of great weakness in the legs. He was, therefore, kept entirely to his bed. After this (Sept. 14th) his condition gradually deteriorated. The paralysis of the left external rectus became more and more marked and finally complete. Slight swelling and haziness of the optic discs were noticed on Nov. 1st. The tongue was still protruded to the left. The paralysis of the soft palate gradually became complete, with constant regurgitation of liquids through the nose. On this account he was fed through a tube passed into the stomach, as it was thought food pneumonia would otherwise inevitably follow. After withdrawing the tube, however, he used to vomit and so he incurred the same risk as before. The nasal intonation increased, the speech became thick, and the words blurred so that it became impossible to understand him. The saliva ran from his mouth and soaked his pillow. He wasted considerably. The knee-jerks entirely disappeared, but the plantar reflexes remained. No anæsthesia on the left side of the face or deafness were ever noticed. The heart's action continued regular, but gradually quickened from 84 to 120 beats per minute, at which rate it remained for some time before his death. The lungs remained quite free till about a week before his death, when bubbling râles were heard at the bases. These increased in number, and were finally heard all over the chest. Cheyne Stokes breathing was never observed. The temperature throughout the course of the disease was inclined to be sub-normal, varying from 96° to 99° F. On Nov. 13th, in the afternoon, after being fed through the tube, he vomited a considerable quantity of fluid. Some of this got into the air-passages, for he became extremely cyanosed and short of breath. He was put on his side and given oxygen to inhale, when some slight improvement followed. He was then fed entirely with nutrient enemata. The improvement, however, was only temporary, for both the pulse and respiration quickened, the temperature rose to 102°, and at 1 A.M. on the 14th he died.

Necropsy.—At the post-mortem examination the bones of the cranial vault were found to be considerably thinned in places. The brain weighed 50 oz. and the convolutions on both sides were flattened; this was due to the distension of the ventricles with clear cerebro-spinal fluid. There was a lobulated tumour as large as a Tangerine orange growing from the anterior surface of the basilar process about the junction of the basi-occipital and basi sphenoid bones. A longitudinal section of the bone showed that the tumour was sub-periosteal and that it did not expand the basilar process. The growth was covered over by the dura mater and had not perforated it in any place. The tumour was white on section and grated under the knife; it presented the appearance of a cartilaginous tumour undergoing calcification; microscopically it was a chondrifying and calcifying sarcoma.

¹ Gowers: Diseases of the Nervous System, second edition, p. 499.